Title 23: Division of Medicaid

Part 200: General Provider Information

Part 200 Chapter 3: Beneficiary Information

Rule 3.7: Beneficiary Cost Sharing

A. The Division of Medicaid does not impose premiums on beneficiaries.

B. The Division of Medicaid does not impose cost sharing on beneficiaries.

Source: U.S.C § 1396a; 42 C.F.R. § 447.50 *et seq.*; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 23-0011 (eff. 5/01/2023) eff. 09/01/2023. Revised eff. 07/01/2021; Revised Miss. Admin. Code Part 200, Rule 3.7.B.h) to correspond with SPA 2012-008 (eff. 10/01/2012) eff. 05/01/2014.

Part 200 Chapter 5: General

Rule 5.3: Wellness Program

A. Wellness Services for Adults

1. Annual Health Screening/Physical Examinations for Beneficiaries for Adults (Age 21 and over)

    a) The Division of Medicaid covers annual physical examinations for adults.

    b) The annual physical examination will not be counted toward the physician visit limit of twelve (12) per fiscal year.

    c) Appropriate age-related screenings such as those listed below will be reimbursed separately when performed as part of the annual physical exam.

        1) Cardiovascular Screening - The Division of Medicaid will pay for an annual screening of cholesterol, lipids, and triglyceride levels.

        2) Diabetes Screening - An annual screening for diabetes is covered. The screening may include appropriate laboratory and urine studies.

        3) Cervical and Vaginal Cancer Screening - A Pap test and a pelvic exam are covered yearly for women.

        4) Screening Mammography - The Division of Medicaid covers annual mammography for women beginning at age forty (40).

5) Colorectal Cancer Screening - A yearly screening for occult blood is covered for individuals beginning at age fifty (50), or individuals who are <50 and identified as high risk. A flexible sigmoidoscopy or barium enema is covered every five (5) years, or a colonoscopy is covered every ten (10) years. High risk individuals have one (1) or more of the following colorectal cancer risk factors:

d) A personal history of colorectal cancer or adenomatous polyps,

e) A personal history of chronic inflammatory bowel disease, either Crohn's disease or ulcerative colitis,

f) A strong family history of colorectal cancer or polyps including cancer polyps in a 1st degree relative [parent, sibling, or child] younger than sixty (60) or in two (2) or more 1st degree relatives of any age, or

g) A known family history of hereditary colorectal cancer syndromes such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colon cancer (HNPCC).

1) Prostate Cancer Screening - A prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) are covered annually for men beginning at age fifty (50). Both screenings are covered annually beginning at age forty-five (45) for men of African-American descent.

2) Bone Density Studies are allowed every twenty-four (24) months for women age sixty-five (65) and older.

3) Vision and Glaucoma Screening eye exams are covered as specified in Part 217 Vision Services.

4) Influenza and Pneumonia Vaccines are covered services for both children and adults under Mississippi Medicaid as outlined in Part 224 Immunizations.

B. Wellness Services for Children (Under Age 21)

1. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, a mandatory service under Medicaid, provides preventive and comprehensive health services for Medicaid eligible children and youths up to age twenty-one (21). Children will access the mandatory periodic screening services through EPSDT providers. EPSDT providers will follow the Division of Medicaid's rules for the EPSDT Program.

2. No co-payment is applicable for services to children under age eighteen (18). The provider must report the co-payment Exception Code "C" on claims for beneficiaries under age eighteen (18). The codes for the periodic screening examinations do not apply toward the physician visit limit per fiscal year.

C. Wellness Services for Dual Eligibles

1. Beneficiaries whose Medicare Part B coverage begins on or after January 1, 2005 will have Medicare coverage for a one time only "Welcome to Medicare" Physical Examination within the first six (6) months of the Medicare coverage.

2. If the beneficiary has both Medicare and Mississippi Medicaid, the routine annual physical examination is not covered under Medicaid if the beneficiary is eligible for or has already received the "Welcome to Medicare" physical examination. The Division of Medicaid will not duplicate benefits for routine annual physical examinations covered by Medicare and will not provide an annual physical examination until twelve (12) months has elapsed from the original effective date of the Medicare Part B coverage. For these instances, it is the sole responsibility of the provider to determine whether Medicare or Mississippi Medicaid is the appropriate billing source.

3. Dual eligibles whose Medicare Part B effective date is prior to January 1, 2005 will be eligible for the physical examination as outlined above for adults or children.

D. Diagnostic and/or Screening Procedures are radiology and laboratory procedures which are a standard part of a routine adult annual age/gender physical examination or well child periodic screening may be billed by the provider performing the procedure, and coverage will be determined based on current Mississippi Medicaid policies for the individual procedures.

E. The Division of Medicaid covers a physical exam for beneficiaries enrolled in the Family Planning Waiver. [Refer to Part 221]

F. The Division of Medicaid does not cover an annual physical examination for:

1. School entrance,

2. Sports,

3. Employment, or

4. Beneficiaries in an institutional setting including those that are in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 23-0011 (eff. 5/01/2023) eff. 09/01/2023. Revised eff. 04/01/2018.

Title 23: Division of Medicaid

Part 200: General Provider Information

Part 200 Chapter 3: Beneficiary Information

Rule 3.7: Beneficiary Cost Sharing

A. The Division of Medicaid does not impose premiums on beneficiaries.

B. The Division of Medicaid does not impose cost sharing on beneficiaries.~~applies cost sharing to the following services in the amounts specified:~~

~~1. Non-emergency hospital-to-hospital ambulance transportation is $3.00 per trip,~~

~~2. Ambulatory Surgical Center is $3.00 per visit,~~

~~3. Dental is $3.00 per visit,~~

~~4. Durable Medical Equipment (DME), orthotics, prosthetics, excluding medical supplies, are as listed below when the items are priced:~~

~~a) $10.00 or less, cost sharing is $0.50,~~

~~b) $10.01 to $25.00, cost sharing is $1.00,~~

~~c) $25.01 to $50.00, cost sharing is $2.00,~~

~~d) $50.01 or more, cost sharing is $3.00.~~

~~5. Federally Qualified Health Center (FQHC) is $3.00 per visit,~~

~~6. Home Health is $3.00 per visit,~~

~~7. Mississippi State Department of Health (MSDH) is $3.00 per clinic visit,~~

~~8. Hospital inpatient is $10.00 per day,~~

~~9. Hospital outpatient is $3.00 per visit,~~

~~10. Physician is $3.00 per visit excluding emergency visits which must have the appropriate exception code entered on the claim,~~

~~11. Prescription drugs are $3.00 per prescription, including refills,~~

~~12. Eyeglasses are $3.00 per pair, and~~

13. Rural Health Clinic (RHC) is $3.00 per visit.

C. The provider must accept the beneficiary's assertion that he/she cannot afford to pay the cost sharing in the absence of knowledge or indication to the contrary.

1. The provider cannot deny services to any Medicaid beneficiary due to the beneficiary's inability to pay the cost sharing.

2. The beneficiary's inability to pay the cost sharing does not alter the Medicaid reimbursement amount for the claim, unless the beneficiary or service is excluded from cost sharing.

D. Collecting cost sharing from the beneficiary is the responsibility of the provider. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing from the beneficiary remains the responsibility of the provider.

E. When the beneficiary is exempt from cost sharing, the applicable co-pay exclusion code must be indicated on the claim. If the co-pay exclusion code is not present, cost sharing will be deducted unless otherwise specified below. The following beneficiaries are exempt from cost sharing:

1. Infants,

2. Children under eighteen (18),

3. Pregnant women,

4. Residents of long-term care facilities,

5. American Indians and Alaska Natives (AI/AN) who are currently receiving or have ever received an item or service furnished by an Indian Health Service (IHS) provider, a tribal health program, or through referral under contract health services. No co-pay exclusion code is required when billing the claim,

6. Beneficiaries receiving hospice care, and

7. Beneficiaries enrolled under the breast and cervical cancer treatment program.

F. When the service is exempt from cost sharing, the applicable co-pay exclusion code must be indicated on the claim. If the co-pay exclusion code is not present, cost sharing will be deducted unless otherwise specified below. The following services are excluded from cost sharing requirements:

1. Services provided to pregnant beneficiaries from day one (1) of pregnancy to day sixty (60) post-partum,

~~2. Emergency services,~~

~~3. Family planning services and supplies including contraceptives and pharmaceuticals,~~

~~4. Preventative services provided to children under eighteen (18), and~~

~~5. Services required due to provider preventable conditions.~~

~~D. For beneficiaries covered under a Home and Community-Based Services (HCBS) Waiver, the beneficiary is exempt from cost sharing if the item or service is reimbursed through the HCBS Waiver. If the item or service is reimbursed through Mississippi Medicaid State Plan benefits, cost sharing is applicable unless the beneficiary is exempted by one (1) of the beneficiary groups or services listed above.~~

Source: U.S.C § 1396a; 42 C.F.R. § 447.50 *et seq.*; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 23-0011 (eff. 5/01/2023) eff. 09/01/2023. Revised eff. 07/01/2021; Revised Miss. Admin. Code Part 200, Rule 3.7.B.h) to correspond with SPA 2012-008 (eff. 10/01/2012) eff. 05/01/2014.

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   a) The Division of Medicaid covers annual physical examinations for adults.

   ~~b) The co-payment amount of $3.00 for a physician visit will not be applicable to beneficiaries age eighteen (18) and over.~~

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   ~~d~~c) Appropriate age-related screenings such as those listed below will be reimbursed separately when performed as part of the annual physical exam.

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